

Helping health and social care professionals to develop an 'inequalities imagination': a model for use in education and practice

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Background. The 'inequalities imagination model' originated from our own research, and led to findings and recommendations regarding clinical and education issues. This article focuses on the creation of the model which, we suggest, could be used to facilitate the development of an 'inequalities imagination' in health and social care professionals.

Aim. To describe and critically analyse the thinking that led to the concept of an 'inequalities imagination' and provide the framework for the theoretical model.

Methodological approach. Influencing concepts from the fields of social work, sociology, nursing and midwifery, and debates around antidiscriminatory and antioppressive practice, cultural safety, cultural competence and individualized care are analysed.

Inequalities imagination model. Ideas generated from an analysis of the concepts of antidiscriminatory/anti-oppressive practice and from the research data led us to conceptualize a flexible model that incorporated issues of individual and structural agency and a broad definition of disadvantage. The literature review underpinning the theoretical framework means that the model has the potential to be truly interdisciplinary.

Conclusions. Professional educators face a difficult task in preparing practitioners to work with clients in ways that take account of differences in background and lifestyle and which respect human rights and dignity. The model makes explicit a process that enables practitioners to think about their current practice and move towards a greater understanding and awareness of the way they work with disadvantaged clients, and ways in which they prepare others to do so. We suggest that professionals develop an 'inequalities imagination' in order to enhance equality of care. The development of an 'inequalities imagination' helps practitioners to bridge the gap between the challenges they face in day-to-day practice and what they need to achieve to aspire to provide equality of care to all.

Keywords: disadvantage, professional education, antidiscriminatory practice, individualized care, reflection, cultural competence, inequalities imagination, midwifery, social work, self-awareness

Introduction

Within the contemporary United Kingdom, policy initiatives have been introduced by central government, that provide mandates for ameliorating health inequalities and for reorganizing service provision. However, it is imperative that anticipated gains made by the introduction of new policies are not lost through lack of forethought about their 'grassroots' operationalization. Of fundamental importance is the consideration of what actually occurs during the day-to-day interactions between health care professionals and their clients. For the often somewhat vague, yet laudable, aims of central policy initiatives to be realized, health care professionals need to work with disadvantaged service users in ways that facilitate health benefits. Many will testify to the positive way in which health professionals work, often in stressful and under-resourced contexts, to achieve this (Hart *et al.* 2001). However, there are also many examples of how interactions between health and social care professionals, institutions and service users result in clients feeling oppressed

and humiliated, rather than cared for (Menzies-Lith 1960, Bloor & McIntosh 1990, Edwards & Popay 1994, Hart *et al.* 2001). In the case of many disadvantaged service users this issue is particularly prominent, and often results in inequalities in access to care provision being exacerbated. There are many complex debates behind these issues, with resourcing, organizational politics and culture, gender, disability, sexuality, ethnicity and socio-economics at the fore. However, ensuring that health care professionals work with disadvantaged clients in a manner that takes account of differences in background and lifestyle, and which respects basic human rights and promotes human dignity is of major importance in realizing the visions inherent in inequalities-focused policy initiatives. We acknowledge that this is no easy task. We understand that the nature of the challenge, and the vast body of research on stress in the health and social professions is testament to this (Giddens 1984, Schaeffer & Moos 1993, Newton *et al.* 1996, Weinberg & Creed 2000). However, as Marshall (1980) maintains, in order to have the best chance of coping effectively with the potentially stressful stimuli inherent in the caring professions, health and social care practitioners must be fully cognizant of their causes and influence, that is to reflect on their practice with specific clients. Furthermore she states that: 'Unless coping with them takes the form of deep confrontation its effects will be superficial and transitory' (Marshall 1980, p. 21).

Our 'inequalities imagination' model is designed to help professionals to do this in a positive way. It is a 'becoming' model in the sense that it recognizes everybody who has a will to develop an 'inequalities imagination' has already started the process. It offers professionals an opportunity to continue this process within a structured format and acknowledges that this is a life long process. Furthermore the model takes into account the fact that different people have different starting points and their differing experiences will impact on their development in particular areas of the model. The model provides a broad, inclusive and creative conceptual tool that we have found, through our teaching and learning in this area, to be useful to other health and social work professionals in meeting the needs of disadvantaged clients.

What is already known about this topic

- Inequalities in health persist and health and social care professionals have a mandate to address this unsatisfactory situation.
- Students and practitioners often find it hard to work with disadvantaged clients in a way that enhances their experience of care.

What this paper adds

- The 'inequalities imagination model' is presented as a framework to help students and practitioners think about their work with disadvantaged clients and the contexts in which they provide this care.
- The model is interdisciplinary, drawing on perspectives from sociology, social work and health care practice.
- It provides practitioners and students with a framework within which to explore challenges to care provision, at both individual and collective levels.

Methodology

The main aim for the research study from which the 'inequalities imagination' model originated, was to investigate the preparation of midwives to deliver effective care to disadvantaged clients. This research gave rise to many findings and recommendations regarding clinical and education issues, some of which are in press elsewhere (Hart *et al.* 2001, Hart & Lockey 2002). However, this article draws on the data from the study to provide the context in relation to which concepts from the different disciplinary fields of social work, sociology, nursing and midwifery, and debates around antidiscriminatory and antioppressive practice, cultural safety, cultural competence and individualized care are critically analysed. This analysis underpins our theoretic framework and the creation of the model which, it is suggested, could be used to facilitate the development of an 'inequalities imagination' in health and social care professionals.

The following table summarizes our research methods and data collection:

Research method	Data collection method
National survey of pre- and postregistration midwifery courses	Questionnaire Telephone interview
Three case studies, selected to represent a geographical spread across England and each with differing levels of social deprivation	Focus group with midwifery students Interview with midwifery students Interviews with preceptors* Interviews with service users Interviews with service managers Interview with maternity link workers Interviews with health advocates Interviews with midwifery service managers Interviews with midwifery tutors Classroom observations

*This term is used both to describe a qualified member of staff who undertakes support and guidance of a newly qualified member of staff and also it is more loosely used to denote an appropriately qualified member of staff who undertakes mentorship and assessment of preregistration students.

Conceptual influences underpinning the theoretical framework

This paper does not attempt to provide a systematic blueprint for teaching about inequalities in health to health and social care practitioners. Rather, we propose a framework within which such teaching might usefully be developed. Nevertheless, in this section we give the reader a brief overview of how we have come to conceptualize inequalities

in health, thereby demonstrating which particular debates have provided the theoretical context of our model.

Different understandings and definitions of disadvantage have informed different models of practice in health and social care. First, we explore some of the ways in which disadvantage has been conceptualized, and suggest that an awareness of these different conceptualizations is important in understanding the theoretical framework supporting our model. Next, we discuss concepts of antidiscriminatory and antioppressive practices and the notions of cultural safety, cultural competence and individualized care. More particularly, we contrast the structurally focused 'antioppressive' model of practice, which enjoys some popularity in social work, with the more individually focused 'individualized care' model dominant in nursing and midwifery, along with social work's other concept of 'antidiscriminatory practice'.

Defining disadvantage

Commentators such as Williams (1983) have made clear that concepts such as 'disadvantage' are always contested, having different meanings, and different referents, in different contexts and at different historical moments. Nevertheless, it is clearly a concept which encompasses individuals whose identities may be constructed in relation to concepts such as impairment, discrimination, prejudice, poverty, social exclusion, inequality, membership of minority group and of low educational achievement. Each of these concepts has a particular historical, social and political significance, and although these may be relatively wide-ranging, they are certainly not arbitrary.

In our research study we explored how, within the context of contemporary British midwifery, the wide range of possible applications of the concept of 'disadvantage' was such that it could be argued that almost every pregnant woman has an aspect of her identity which could be identified as 'disadvantaged' (Hart *et al.* 2001). Our model encourages practitioners and students to be aware of broad definitions of 'disadvantage' and related concepts such as ethnicity and gender. However, in order to focus the analysis, the possible characteristics or experiences of people that might contribute to their being classified as 'disadvantaged' can be divided into the following five categories:

- 1 Mental or physical impairment
- 2 Particular characteristics which have led historically to individuals experiencing prejudice and discrimination (e.g. ethnicity, gender, etc.)
- 3 Clients who experience prejudice
- 4 Clients who experience discrimination
- 5 Clients living in material poverty

Categories (1) and (2) could be said to be primarily related to the person (internal locus), whilst categories (3) and (4) are concerned with the manner in which other individuals and institutions relate to individuals in categories (1) and (2). Category (5) is one that could be consequential to any of the other four. However, it is certainly the case that all five categories may be applicable in relation to health care provision for certain individuals.

The use of our 'inequalities imagination' model which we describe below, encourages practitioners and students to reflect on the lived experience of individuals who, in the context of health and social care, represent a constellation of the above categories. It emerged from our research study that it is precisely such individuals who represent the greatest challenge to midwifery care, not least because of the problems midwives had in defining and recognizing disadvantage in such a way that appropriate care can be offered. The problems that midwives had in this regard are likely to be experienced by other practitioners, thus taking into account constellations of disadvantage with respect to individual clients remains an important challenge for assessment and care delivery.

Most commentators acknowledge that disadvantage is socially constructed in some way and that the experience of disadvantage is always affected by wider social, economic and political forces (Nettledon 1995). However, the precise interplay between social constructions and material, structural 'realities' of disadvantage continues to be widely debated in the social sciences (for example, Ussher 1997, Bartley *et al.* 1998) and the consequences of this interplay for health and social care practice continues to be addressed (e.g. Clark *et al.* 1991, Benzeval *et al.* 1995, Bywaters & McLeod 1996, Robinson & Elkan 1996, Crafter 1997). Our model gives a framework within which practitioners and students can be encouraged to reflect on how it is possible to see 'disadvantage' as constructed, in part, in the practice of delivering care. In the case of any one individual client, there could be said to be a 'working definition' of her particular disadvantage which is, itself, potentially the outcome of negotiations between different stakeholders, including the client herself, her family, and the various professionals involved in her care. Thus, we do not seek to offer a fixed definition of disadvantage. Rather, we are concerned to identify the different definitions in play, the conflicts they generate and the resolutions that are found in specific contexts.

Debates about what constitutes disadvantage are, of course, linked to wider debates within the social sciences about what constitutes reality and, indeed, whether it is even justifiable to talk about a 'real world' which exists outside of an individual's experience of that world. Thus, debates have focused on the relative importance of *structural* and

individual factors in constituting social experience. Most commentators insist on the interplay between structural and individual factors. Social, economic and political contexts play a major role in structuring the lives of individuals. However, those individuals, via their own agency, play a role in defining and shaping both their own experiences and, ultimately, too, the very structures that would seek to define them (Giddens 1984, Popay *et al.* 1998).

This debate has relevance for health and social care professionals, who have to remain aware of both structural and individual aspects of disadvantage throughout their practice, including their own contribution to formulating a client's identity and experience (Brechin 2000) and that of the institutional structures within which they work (Gerrish 1999). They may draw on macro studies employing epidemiological and statistical data to enhance their awareness of the possible structural inequalities (economic, social and/or cultural) faced by, for example, physically disabled clients. However, they may also need to draw on the more micro sociological research to enable them to remain open to the possibility that individual disabled clients may experience their disabilities in vastly different ways, and that the role of professionals can influence this situation. It is only by drawing on all these approaches that practitioners can deliver appropriate care. Within the health and social care field there are many texts which practitioners and students can draw on to help them understand the complexities of inequalities in health (Robinson & Elkan 1996). However, there are few studies which give a framework for exploring inequalities as part of an educational process, both within classroom teaching settings and in practice. Our model offers such a framework, within which the substantive debates may be explored.

Our model aims to incorporate the perspectives of clients as central to health and social care professionals' education and practice. However, it does so within a framework that understands 'disadvantage' and the experience of disadvantage as being constituted within a set of relationships involving:

- the client,
- health and social care institutions,
- health and social care professionals.

With this in mind, debates concerning the nature of anti-oppressive and antidiscriminatory practice become extremely relevant. Such approaches recognize not only the *dynamic* nature of the construction of a 'disadvantaged' identity in relation to debates about structure and individual agency, but also the relevance of debates about the role and approach of health and social care professionals. They also acknowledge the importance of the concept of *power* when analysing the relationships between professionals and clients (Brechin 2000).

Relations between anti-oppressive, antidiscriminatory and individualized care models of practice

Both anti-oppressive and antidiscriminatory agendas are common in social work. Within social work, anti-oppressive practice is associated with the practice of challenging structural inequalities (Preston-Shoot 1995).

Anti-oppressive practice can be understood as presenting a radical challenge to existing structures of power. It is focused less on equal opportunities and access and more on equality of outcome. It is about the empowerment of individuals in terms of their 'rights' not simply their 'needs', and focuses on the development of active citizenship amongst clients rather than simply demanding that all clients are respected for who they are. Thus, there is clear recognition in this model that individuals must be empowered to contribute to changing the very structures that disadvantage them.

The antidiscriminatory model of practice is often defined in ways that make it indistinguishable from the anti-oppressive model but neither is without critics. The precise relevance and practicality of such practices have been hotly debated since 1994. Preston-Shoot (1995), in particular, has argued that anti-oppressive practice is more radical than antidiscriminatory practice in that it challenges both structural and individual aspects of inequality and disadvantage but others argue that even anti-oppressive agendas are unlikely to bring about significant reductions in inequality (Williams 1999, p. 226).

In the health care field, too, there is debate about the relative importance of 'structural' and 'individual' aspects of disadvantage and inequality. For example, the field of 'transcultural nursing' has, for some time, concerned itself with the issue of nursing in specific cultural contexts (Leininger 1991). Transcultural nursing espouses the need for 'culturally sensitive' care, with health care interactions being central. However, recent commentaries on transcultural nursing have criticized this approach for its failure to address structural factors within which those health care interactions take place (Polaschek 1998).

As part of a critique of transcultural nursing, the concept of 'cultural safety' has been generated in work in both New Zealand and Australia on nursing people of different ethnicity to that of the nurse:

'Safety' in cultural safety, derived from the idea of safety in nursing, suggests a standard that must be met or one's activity is unsafe. However, it is recognised that it is not analogous to other forms of physical safety but is more like an adequate ethical standard (Polaschek 1998, p. 452).

The notion of cultural safety, like the concepts of anti-oppressive and antidiscriminatory practice, can be seen to

place emphasis on the role and attitude of practitioners in constituting disadvantage, rather than focusing solely on the identity and experience of the client (for example, see Sayce 1998). Culturally *safe* nursing practice then, is that which involves actions, which recognize, respect and nurture the unique cultural identity of individuals and safely meet their needs, expectations and rights (Wood & Schwass 1993).

Despite the popularity of 'cultural safety' as a concept in New Zealand, and despite the fact that it has been adopted at policy level in that context (Ramsden 1995), it has also been criticized (Polaschek 1998). One area of debate concerns the extent to which the concept can be applied in other contexts. Some commentators advocate widening the application of the concept of cultural safety to other forms of oppression such as sexism, ageism and homophobia (Ramsden 1995), but others suggest that this would diminish the power of the concept (Polaschek 1998).

Like transcultural nursing, cultural safety has also been criticized for focusing too much on micro interactions between clients and practitioners, at the expense of wider structural issues. Furthermore, the vague nature of the concept has also been called into question (Polaschek 1998), as has its emphasis on nurses' *attitudes* rather than *behaviours*. Despite these criticisms, it is clearly a concept that has relevance to the development of our model, precisely because of its emphasis on the role of practitioners in either reinforcing or challenging disadvantage.

Campinah-Bacote's (1999) work on cultural competence is also relevant. She suggests that the process of cultural competence in the delivery of health care services is one of striving towards rather than assuming achievement. The first of five aspects of her model, is cultural awareness, which requires appreciation of and sensitivity to values and beliefs of a client's culture but involves the examination of the possible ethnocentricity of one's own values and beliefs. The fifth aspect of the model, that of cultural desire, is 'the motivation of the health care professional to "want" to engage in the process of cultural competence'. She explains that although health care providers might possess cultural awareness, knowledge and skill, without an honest commitment to care, these become meaningless politically correct words. This sentiment can be seen to transfer across all types of disadvantaged service users but again the model focuses on the micro interaction between the client and practitioner and does not fully address structural issues.

A further concept which places emphasis on micro-interactions, but which has the potential to encompass an awareness of structural factors is that of 'individualized care'. This, as our research study demonstrated, is the philosophy underpinning contemporary midwifery practice

(Hart *et al.* 2001). However, we demonstrate within our study that this has not been related to other concepts and practices that seek to define and address disadvantage and inequalities. Individualized care is about meeting women's individual needs but the concept of 'need' in the midwifery context is complex and the concept is inconsistently applied by midwives (Hart *et al.* 2001). Some midwives may well take 'individualized care' to mean 'according to the wishes of that particular woman'. Other midwives will make their own professional judgements about appropriate care on the basis of their perception of the woman's needs, which may be informed by either individual and/or structural definitions of disadvantage. Similar points can be made in relation to the concepts of 'holistic' and 'woman-centred' care, both of which are often used synonymously with 'individualized care' in the midwifery context. Thus the notion of 'individualized care', 'holistic' and 'women centred care' may or may not include attention to structural issues depending on how the individual midwife defines them. The 'liberal' approach to inequality, reflected in the 'individualized care' approach, is often very ambiguous about difference and equality issues. At best, cultural and other 'differences' are recognized and respected. Rarely are they understood in relation to 'disadvantage' in a more overtly structural and political sense as in social work policy.

Until recently, there has been no specific *requirement* for nurses, midwives and health visitors to address issues of inequalities in health in their practice. It is then perhaps unsurprising that these issues have not been debated in the midwifery literature. However the introduction of the United Kingdom Central Council for nurses, midwives and health visitors competencies and the recently published academic and practitioner standards (Quality Assurance Agency for Higher Education 2001) will bring greater attention to these issues. As a consequence, it may be the case that more attention will now be paid to facilitating students and practitioners in this complex task, rather than simply focusing on understanding the inequalities faced by clients. Our model aims to contribute to this debate by providing a framework within which understandings of inequalities can explicitly be operationalized in the health and social care context.

Inequalities imagination model

Ideas generated from the above theoretical inquiry and from the research data led us to conceptualize a flexible model that incorporated issues of individual and structural agency and a broader definition of disadvantage (Figure 1). We realized that because of the diversity of the client group, their

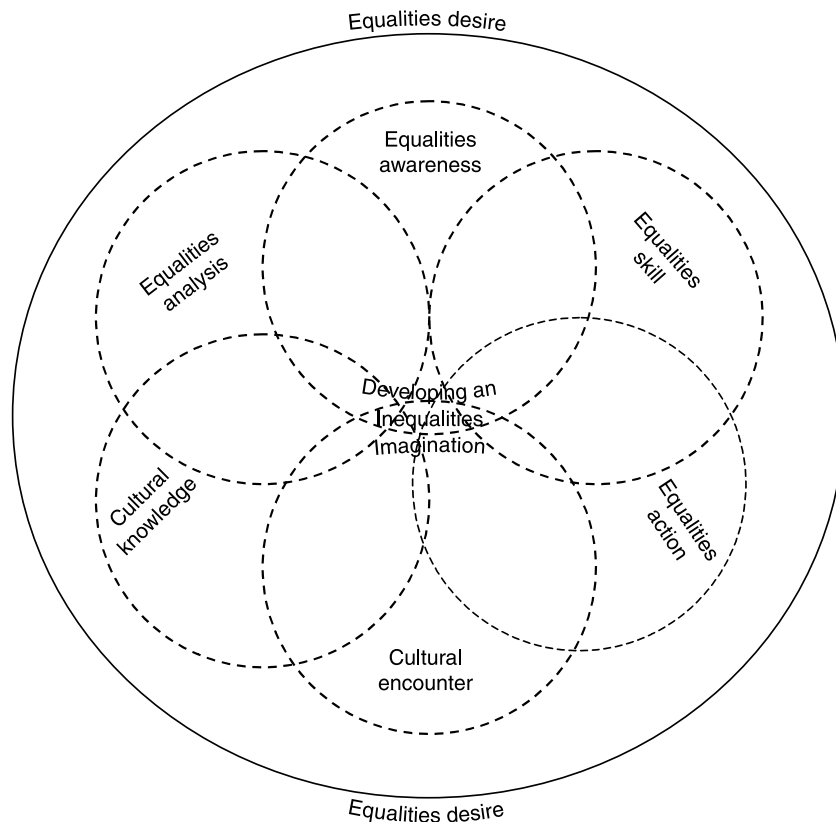


Figure 1 Developing an inequalities imagination.

individual needs and associated structural issues of inequalities, a flexible model was needed, which focused on the practical issue of how practice could be improved. The model enhances the practitioners' awareness of their own part in working to address individual clients needs and challenging structural inequality. In the following section we expand the idea of developing an 'inequalities imagination' more fully.

We chose to use the concept of 'imagination' in order to describe the process whereby practitioners are encouraged to bring to mind previous situations and to consider how they might have acted differently. Of course, some practitioners may not have worked with disadvantaged clients before and the use of imagination here can help them create and work with mental images of what has not yet been experienced. The use of imagination allows practitioners to rehearse future behaviours internally without the risk of exposure to real life. Imagination allows us to become someone else for a time, to see things from perspectives other than our own and therefore it can be used as a means of developing empathy (Mulligan 1992). This last characteristic is particularly important to the development of an 'inequalities imagination' in those who have no direct experience of the particular disadvantage facing the client. This type of imagination process is equally important when a professional believes that they have gained empathy through having experience of the same disadvantage. Although this one aspect of their experience may be similar, other personal circumstances will be different and the client's situation is unique. In this sense, the notion of 'imagination' allows students and practitioners to harness creative resourcefulness, and it implies a loosening up of thinking.

However when creating such images some aspects of the situation may remain at a subconscious level meaning that the user is not fully aware of their effect on their thinking and behaviour. Therefore it is important to try to make explicit these previously constructed images in order to expose, explore and guide current thinking and action. In an exploration of students' images of themselves as social workers, Gould and Harris (1996, p. 234) suggest that 'initial images of a profession offer the novice a powerful frame in which to locate professional practice and behaviour'. Previously met role models from whom the practices and behaviours are remembered, were the basis for the students' image of the professional person they wished to be or not to be. In their study this was often drawn from personal or a friend's experience. These images may be in line with current role models within particular professions, but Gould and Harris suggest that within the education process they are rarely addressed. This is despite the fact that research into teacher education shows that these frames of reference

persist throughout the course. Rigid images can reinforce previous blinkered thinking but we suggest, following Morgan (1993), that images and metaphors can be manipulated through (facilitated) reflective sessions. This is an important issue because as Morgan also points out these existing perspectives, assumptions, mind sets, life views and frames of reference lead people into seeing things in a particular way and then to repeat past behaviours. His advocated use of images and metaphors is aimed at getting people to think differently and potentially change their planned goals.

Our emphasis on developing an 'inequalities imagination', encourages a commitment to thinking and acting creatively in reducing the inequalities that persist between humans. Thus it transcends a focus simply on discourses of inequalities and disadvantage. We maintain that a key aspect of developing an 'inequalities imagination' involves putting into practice a questioning approach to the subject of inequalities and disadvantage. It also involves thinking of the different constellations of disadvantage that may come into play for each individual client. In this way the model encourages activity beyond the purely conceptual.

The development of an 'inequalities imagination' can complement the notion of 'individualized care' prevalent in nursing and midwifery education and practice. It implies thinking beyond a very limited sense of individualized care (what the individual client says she wants or needs) to a much more analytic and creative approach that recognizes both the structural and individual factors that determine and define needs in contemporary society. In order to be successful this skilled activity requires understanding of self in relation to others, the use of empathy and sensitivity and an appropriate knowledge base.

This mix of skills as highlighted in our model, is similar to the components described in Campinha-Bacote's (1999) model of the process of developing cultural competence. Whilst her exploration of cultural competence relates to race and ethnicity we believe her model can be expanded to take into account the wider issues relating to disadvantaged clients and the process of developing an 'inequalities imagination'.

Campinha-Bacote's model consists of five components: cultural awareness; cultural skill; cultural knowledge; cultural encounters and cultural desire, each of which is integral to the process of developing cultural competence. The findings of our research study support the importance of these components. However, we suggest that her cultural competence model as it stands, best describes the development of competence in the direct relationship between a professional and an individual client. It does not recognize a role for the practitioner explicitly in questioning the structural systems that perpetuate inequality. In this sense,

Campinha-Bacote's model is antidiscriminatory, rather than anti-oppressive.

For our purpose then, we have built on Campinha-Bacote's model, adapting and extending it to make more explicit the need to take a questioning approach not just to the care given to individuals but also to the systems of care delivery. Furthermore, in some aspects of her model we replaced the emphasis on culture with an emphasis on equalities, and our understanding of the notion of 'culture' is broader than that of Campinha-Bacote, and goes beyond notions of ethnicity to include wider issues of difference.

The description of the model (Figure 1) starts with (*equalities*) *desire*, which is to us, the most important component. This is represented as the will to develop competence which is based on 'caring which begins in the heart and not the mouth' (Campinha-Bacote 1999, p. 205). This is a significant part of the process involved in developing an 'inequalities imagination'. Without this essential ingredient use of other parts of the model may result in 'politically correct' behaviour alone, rather than a genuine attempt to value and respect clients as people and demonstrating a commitment to reducing inequalities. (*Equalities*) *awareness* is constituted by the deliberate attempt to look beyond one's immediate circumstances and gain a deeper awareness of self in relation to others. This involves examining self and exposing one's biases and prejudices. As in Campinha-Bacote's model we see (*cultural*) *knowledge* as the process of seeking and obtaining a sound educational foundation for understanding the world view of others but also the acquisition of knowledge about epidemiological, biological and psychological aspects specific to the client or client group. This information is necessary to enable (*equalities*) *skill* in collecting appropriate information about the client in order to undertake assessment and plan to deliver appropriate care. (*Cultural*) *encounter* depends on continued exposure to a diverse range of clients, which enables the continual improvement of equalities skills together with a renewed opportunity to examine one's (*equalities*) *awareness/perspective*. As Campinha-Bacote points out engaging in such encounters can be difficult and uncomfortable at times as indeed we have found in our own research in this area (Hart *et al.* 2001). Continued encounters may not be possible for some practitioners depending on their geographical location which may lead to loss of skills.

A further component, which we have introduced within the model, is that of (*equalities*) *analysis* which represents the development of a questioning approach to the social construction of disadvantage and its relationship to the ways in which the structure of health and social care delivery systems reinforce inequalities. The final component that completes

our model of the process of developing an 'inequalities imagination' is the notion of (*equalities*) *action*. This incorporates the notion that a student, lecturer or practitioner engages in actual activity which should lead to challenging inequalities, although there is flexibility within the model with regard to what such action will consist of. Our practice and teaching experience suggests that how the individual components of the model are operationalized by different students and practitioners leads to lively debates, as well as to individuals setting their own goals for self-development.

Our model then encompasses biological, psychological, and sociological dimensions across cognitive and affective domains in order to describe the components necessary in the development of an 'inequalities imagination'. However, it is important to stress that we see the model as a striving towards continued development of this imagination, rather than expecting that it is possible to have an individual to have a complete 'inequalities imagination'. We emphasize here *development* rather than *accomplishment* because no matter how experienced practitioners become, the uniqueness of clients with their individual constellations of disadvantage require practitioners to constantly re-evaluate their thinking and behaviour. The greater the expertise in the component parts the greater and more expansive the imagination becomes. Furthermore, individuals may develop different aspects of the model at different rates, hence the unbounded area of imagination development within the centre.

Despite claims that within the midwifery context students are taught to practice in antidiscriminatory or anti-oppressive ways, our research (Hart *et al.* 2001) suggests that this is often an unrealistic expectation to place on preregistration students, who are still coming to terms with basic clinical competencies and who may feel relatively powerless within the practice environment. Thus the notion of requiring both student and qualified professionals to develop an 'inequalities imagination' is, in some senses, less ambitious than asking them to implement antidiscriminatory or anti-oppressive practice, both problematic concepts, in themselves. The 'inequalities imagination' idea is a positive concept that recognizes that such change is a gradual, on-going, developmental process. It offers a framework within which to reflect on opportunities for some success, a chance to 'get something right' as well as a chance to reflect on and assess how things might have been done differently.

Conclusion

In this article we have argued that the concept of developing an 'inequalities imagination' provides a potentially useful

tool with which to think about how health and social care professional education and practice might be improved to enable professionals to meet the needs of disadvantaged clients more fully. Furthermore, we have demonstrated the various conceptual influences on our model, and have explored our debt to Campinha-Bacote's work. There is a considerable literature base that can facilitate in students, lecturers and practitioners a better understanding of inequalities in health and their own role in ameliorating or perpetuating them. However, given the complexities involved, both education and practice may benefit from an explicit framework within which these ideas can be taken forward. Our inequalities imagination model begins to provide this, and we have had some success with its use in our own teaching and practice. Nevertheless, further research would be needed to fully understand how the model itself really works in practice.

It is easy to become locked into established ways of doing things and to neglect potentially useful ideas and initiatives that do not immediately fit with overall philosophy or existing practices. In this way our model suggests a move beyond the nursing and midwifery philosophy of individualized care.

The proliferation of guidelines and protocols for clinical effectiveness may also seriously inhibit professionals from fully realizing such an imaginative way of working. Addressing 'inequalities' is not a straightforward concept or problem that can simply be taught about/learned about via the acquisition of 'facts', or be 'straitjacketed' into a guideline. It involves a complex interaction between facts, theory, experience, beliefs, values and resources. We see this as a long-term, on-going process of knowledge acquisition, experience via practice and reflection that occurs through processes of both formal and informal learning. Our research, teaching, and practice experiences suggest that professionals need to develop their 'inequalities imagination' in order to bridge the gap between the challenges they face in their day-to-day practice and what they need to achieve to aspire to equality of care to all.

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